Infectious Disease Epidemiology Section
Office of Public Health, Louisiana Dept of Health & Hospitals
800-256-2748 (24 hr number) – (504) 568-5005
www.oph.dhh.state.la.us

Brucellosis Case Surveillance Report

Investigation Information

Investigation ID	**Part of an outbreak?** *Yes No Unknown*	**Outbreak Name**
Investigation Status *New Active Completed Superceded Cancelled*	**Case Status** *Confirmed Not a Case Probable Suspect Unknown*	

Patient Status *Inpatient Outpatient Died*	**Patient Status Date** mm/dd/yyyy	**Diagnosis Date** mm/dd/yyyy	**Onset Date** mm/dd/yyyy

Patient Information

First	**Last**	**Middle**

Street Address

City	**County**	**State**	**Zip**

Home Phone ###-###-####	**Ext.**	**Other Phone** ###-###-####	**Ext.**

Parent/Guardian (required if under 18)

First	**Last**	**Middle**

Demographics

Sex *Male Female Unknown*	**Date of Birth** mm/dd/yyyy	**Age**	**Age Units** *Days Months Years*

Race
Caucasian African American American Indian/Alaska Native Hawaiian/Pacific Islander Asian Unknown Other (Specify)

Ethnicity *Hispanic/Latino Non-Hispanic/Latino Unknown*	**Worksites/School**	**Occupations/Grade**

Referral Information

Person Providing Referral

First	**Last**	**Phone**	**Ext.**	**Email**

Primary Physician

First	**Last**	**Phone**	**Ext.**	**Email**

		###-###-####		

Street Address			
City	**County**	**State**	**Zip**

Clinical Information

or activity, contact with animals, species and frequency, place of contact, dates, etc.) Use the Comments or Additional Information box to specify additional information about recrudescent cases or those with insidious onset (type of work

This Onset was: *Acute Insidious Not Stated*	**Duration of Current Illness (wks.):**

Is this a recurrence of the illness? *Yes No Unknown*	**If Recurrence, Date of Original Onset :** mm/dd/yyyy	**Original Onset was:** *Acute Insidious Not Stated*

Symptoms	**Present?**	**Duration or Severity**
	Y=Yes N=No UNK=Unknown	
Fever, Intermittent		
Fever, Constant		
Chills		
Weight Loss		
Sweating		
Body Ache		
Weakness		
Headache		
Malaise		
Anorexia		
Abscess (Bone, Joint, Muscle)		
Other		

If Other, specify:

Therapy Type	**Therapy?**	**Duration**	**Route of Administration**
	Y=Yes N=No UNK=Unknown		
Tetracycline			
Streptomycin			
Sulfonamides			
Bed Rest			

Other			

If Other, specify:

Laboratory Information

Test Name/Test Method	Date Specimen Collected	Result	Laboratory Name
	mm/dd/yyyy		

Epidemiologic Information

Type of Work or Activity at Onset:

Animal Contact within 6 Months Prior to Onset: *Yes No Unknown*	**If Yes, specify place and dates:**

Commercial Establishments (includes stockyards, slaughterhouses, packinghouses, dairies, meathandlers, etc.)

Animal Contact	Brucellosis Status	Abortions Noted
	1=Present 2=Not Present 3=Under Investigation 9=Unknown	
Cattle (Beef)		
Cattle (Dairy)		
Swine		
Other		

If Other, specify:

Family Owned Animals

Animal Contact	Brucellosis Status	Abortions Noted
	1=Present 2=Not Present 3=Under Investigation 9=Unknown	
Cattle (Beef)		
Cattle (Dairy)		
Swine		
Other		

If Other, specify:			
Use of Milk or Milk Products			
Type of Product	**Pasteurized?**	**Date of Last Consumption Prior to Onset**	**Source of MILK**
	Y=Yes N=No UNK=Unknown	mm/dd/yyyy	

Epidemiologic Information cont.	
Exposure to Brucella Vaccine? *Yes No Unknown*	**If Yes, Date and Type of Exposure:**
County Under Control Program? *Yes No Unknown*	**If yes, indicate:** (Check all that apply) *Modified Certified (Bovine) Certified Free (Bovine) Validated (Swine)*

Other Information				
Local 1		**Local 2**		
Name of Person interviewed	**Relationship to patient**	**Date of interview** mm/dd/yyyy		
Submitted by:	**Date** mm/dd/yyyy	**Health Department**	**Phone Number** ###-###-####	**Ext.**

Other Information cont.

Comments or Additional Information

Other Information cont.

Comments or Additional Information